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MILITARY MEDICINE IN LOW INTENSITY CONFLICT:

A STRATEGIC ANALYSIS

BY

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Military medical personnel and units have participated and will continue to participate in U.S. low intensity conflict (LIC) operations. Previous missions have included care of U.S. personnel, training of host nation medical personnel, disaster medicine during peacetime contingency operations, and, most frequently, medical humanitarian/civic action. U.S. efforts in this area have suffered from the lack of a coherent strategy for using military medicine in LIC. This paper begins with an analysis of the pressures which lead to involvement of military medicine in LIC. The defined ends to which military medicine is directed in LIC are presented followed by the ways in which it contributes to those ends and the means by which operations are conducted. Guidelines for successful military medicine operations in LIC are also detailed. The author proposes a range of new organizations and personnel specialties to strengthen military medicine's contribution to LIC operations and doctrine.

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MILITARY MEDICINE IN LOW INTENSITY CONFLICT: A STRATEGIC ANALYSIS

AN INDIVIDUAL STUDY PROJECT

by

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ABSTRACT

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Military medical personnel and units have participated and will continue to participate in US low intensity conflict (LIC) operations. Previous missions have included care of US personnel, training of host nation medical personnel, disaster medicine during peacetime contingency operations, and, most frequently, medical humanitarian/civic action. US efforts in this area have suffered from the lack of a coherent strategy for using military medicine in LIC. This paper begins with an analysis of the pressures which lead to involvement of military medicine in LIC. The defined ends to which military medicine is directed in LIC are presented followed by the ways in which it contributes to those ends and the means by which operations are conducted. Guidelines for successful military medicine operations in LIC are also detailed. The author proposes a range of new organizations and personnel specialties to strengthen military medicine's contribution to LIC operations and doctrine.

INTRODUCTION

Military medical personnel and units have participated in low intensity conflict (LIC) throughout history. The element that has been lacking is a defined strategy for their use. This paper will analyze the strategic elements--the ends, ways, and means--that govern the uses of military medicine in LIC. The author will describe specific functions of military medicine in the four basic forms of LIC and offer a set of guidelines for success. Following the appraisal of ends, ways, and existing means, the author will propose the creation of additional means to enhance future US LIC capabilities.

Perhaps the most common image of medical activities in LIC is the Vietnam War Medical Civic Action Program (MEDCAP). One participant left this indelible image of one of these operations:

> The sergeant in charge of the marines was yelling at his men to keep in line. "Don't give any of those little bastards candy. They'll start a goddamn riot, and we'll never get the Doc organized. Stay out of the goddamn huts. Don't proposition the women. Keep your weapon in your hands at all times. Keep your clips in, but keep your gun on safety. Only smoke American brand cigarettes, and don't all stand together."
>
> "Drivers, stay in your vehicles, keep the keys in your pockets and your eyes open. These kids will steal you blind. Look relaxed and trusting and friendly." I thought to myself that if any of these people speak English, we were through right now. We had lost their minds and hearts.

> [The physician is asked later to see one elderly women who was too ill to come to him. She was terminally ill with cancer, covered in vomitus, and incontinent of stool and urine. She smiled.] "She knew her war was almost over." [The unit's Medical Service Corps officer supplies the explanation for the dying woman's smile.] "She was glad you were the last foreign SOB who would ever try to win her mind and heart. She was gonna fool us all and die still keeping her own ... mind and heart."[1]

Although perhaps exaggerated, this view of the futility of MEDCAP operations was widely shared by participants in that war. The origins of MEDCAP are beyond the scope of this paper. However, these operations grew out of a situation that has recurred many times since then and undoubtedly will be encountered in future LIC environments.

The typical situation in which US military medical units are deployed in peacetime contingency operations, counterinsurgency operations or mixed operations such as Joint Task Force-Bravo in Honduras is one of considerable excess medical capacity. Force planners tend to size the medical force according to some maximum credible event, typically combat. It is characteristic of medical support in combat that a force adequate to deal with the casualties from intense combat will be much larger than that needed for disease, non-battle injuries, or low level combat. The presence of this excess capacity is reassuring when viewed against the worst possible contingency. However, at other times the size and support requirements of such a large medical component can look burdensome. Operational commanders are understandably anxious to employ these expensive assets in the furtherance of the mission.

The medical commander needs to keep his or her staff busy to preserve their morale and technical competence, keep them from being syphoned off on other details, and ultimately protect the medical share of the force in the area. The preceding are essential to preserving the medical unit's ability to accomplish its primary mission of casualty care for US forces. However, during periods of prolonged inactivity, these secondary purposes can take on a status of their own.

Additional pressure toward MEDCAP operations or the like comes from the ever-present need to maintain good public relations in the United States. Non-violent activities that seem to contribute to the well-being of the host country are much more presentable in the mass media than combat operations. Also, the typical openness and lack of classification of humanitarian activities make them more accessible to news people without risking compromise of operational security.

Arguably, in recent experiences the strongest pressure for medical civic action has come from the humanitarian impulses of medical people themselves. A mixture of boredom and a commendable desire to help the citizens of the host country has led many physicians, nurses and other professionals to seek opportunities in the local communities where they are deployed. It should be recalled, however, that most of the commanders and staffs of medical units deployed in recent operations have been clinicians, frequently practitioners of the most high-technology, tertiary hospital based specialties. These professionals tend to see

medicine from their own experience and to underestimate the differences between medicine as they know it and the real health needs of the population of the host country.

At higher bureaucratic levels such as Headquarters, Department of the Army and the Office of the Secretary of Defense, comparable pressures encourage interest in medical participation in LIC. Leaders at these levels feel the need to be involved in as many aspects of military policy and strategy as possible. Such involvement is essential to protect medical force structure and funding and, possibly, to forestall efforts to civilianize the military medical establishment.

Within the Unified Command headquarters, many of the same pressures play upon the CINC's Command Surgeon. For reasons of zeal as well as career enhancement, these physicians actively seek opportunities to support the CINC's programs and advance US interests in the AOR. As discussed earlier, however, many physicians serving in these areas are clinicians whose background is in hospital based medicine and not in health administration, public health, or medical logistics.

While the preceding list of institutional pressures and concerns is understandable, nothing on the list can be taken for a coherent strategy for medical participation in LIC operations. Before doctrine can be written and certainly before maximum effectiveness can be achieved, a clear understanding must be developed of the strategic ends, ways, and means for using military medicine in LIC.[2] The thesis of this article is that military

medicine, even in its most altruistic guise--humanitarian/civic action--is an instrument of national LIC strategy. The author rejects the view that humanitarian/civic action can or should be separated from LIC strategic doctrine.[3]

ENDS

The following statement may seem self-evident, but it deserves repeating: the universal end which all US military strategy must serve is the furtherance of our national interests. Without this basis for direction, military strategy and action become not just pointless, but potentially dangerous. US national interests vary from one theater to another depending on proximity, resources, threats, and environments. However, the ways and means by which military forces advance those interests can be categorized into the standard nosology of: high intensity conflict (HIC), mid-intensity conflict (MIC), and low intensity conflict (LIC). Within the rubric of LIC, US doctrine recognizes four basic operational categories: support for insurgency and counter insurgency, combatting terrorism, peacekeeping operations, and peacetime contingency operations.[4] Counter-narcotic operations have been added most recently to the list. The approach this paper will take is to define within these categories the ends, ways, and means of a strategy for using military medicine in support of LIC operations.

The first and most obvious end served by military medicine in LIC or any other form of conflict is the maintenance of our troops' physical readiness. In other words, military medicine makes our

people fight better.[5] Regardless of the specific function they are performing, whether it is fighting, building roads, or monitoring narcotrafficking, health is essential to success. Most LIC occurs in the less developed nations of the earth in which the greatest threats to health for both the local population and our personnel are endemic diseases and harsh climates. Innumerable historical examples can be cited in which the outcome of a campaign was either influenced or, in fact, dictated by the inability of troops to remain healthy. One example is the elimination of Napoleon's troops by yellow fever during their attempt to suppress the rebellion in Haiti. The recent success of US operations in LIC environments has been aided greatly by our ability to prevent disease and environmental injury in our troops.

To be sure, no system of preventive medicine is perfect nor can combat casualties be reduced to zero. Some US personnel will fall ill or incur injuries and will require evacuation. Especially in LIC environments, the US ability to evacuate patients to full-service medical facilities provides a key support to the morale of our troops. An additional value which rapid medical evacuation provides is mobility. Prompt evacuation of patients allows units to maintain the speed of operations and preserve the initiative that is often the key to success.

Once a patient has been evacuated, treatment of the injury or disease serves two essential purposes: the preservation of life and function and the prompt return of trained service members to duty. Clearly, the first purpose needs little explanation beyond

a reminder that the assurance of the best possible medical care is a mainstay of morale. However, the key role of medical care in returning personnel to duty is often overlooked. Depending on how far back in the evacuation system the patient receives treatment, he or she may be ready for duty in or near the theater. Moreover, the time element favors treating soldiers and returning them to duty from every level of the evacuation chain. A serious condition might keep a service member out of action for several weeks or months. However, procurement and training of a replacement will typically take much longer, especially in the case of a highly skilled specialty.

All the force multiplying effects of medical care for our troops have their application to helping friendly troops fight better as well. This is the second end military medicine serves in LIC. Since friendly troops are typically native to the region, it might seem that prevention is less of an issue. In many cases, however, prevention is every bit as necessary for indigenous personnel as for foreigners. Many local troops may be chronically infected with the diseases endemic to the area. The troops may be able to function but their effectiveness would be greatly improved by eliminating the burden of disease. In other situations, local personnel may be well adapted to the urban environment in which they are based yet be susceptible to diseases found in rural areas or jungles in which they have to operate. Lastly, many military units in less developed countries serve primarily as security forces in urban centers. These units often lack field experience

and acclimatization to sylvatic environments even in their own countries.

Local troops operating in the field have the same need for medical evacuation and treatment as US troops. These essential medical functions provide the same support to successful operations as in any military force. In addition, many of the countries in which LIC operations occur have no equivalent of the Department of Veterans Affairs nor do they provide disability retirement for incapacitated personnel. Consequently, the military medical care systems in those countries must provide rehabilitation services for injured soldiers. These services may include prosthetic limbs, retraining, etc. An additional function performed by some countries' military medical care systems is some form of disability retirement. This function may be carried out by lifelong domiciliary care or by employing disabled soldiers in hospitals or other facilities operated by the forces. In 1976, the author visited a military hospital in Asuncion, Paraguay that was still holding patients from the Chaco War of forty years earlier.

The third major end served by military medicine in LIC is direct mission support through humanitarian/civic action (HCA). Although in the process some direct patient care is provided, the real interests served are psychological and political.[6] In the kinds of counterinsurgency operations the US conducted in Vietnam, Honduras, and elsewhere, medical humanitarian missions such as the one parodied in the introduction were fundamentally psychological operations. As such, the goal of the operations must be kept

clearly in mind. The end is to reinforce the Clausewitzian trinity between the people, the government, and the army. However, too often the US has forgotten which army and government and people were at issue. In counterinsurgency, psyops should aim the best light possible on the host government, not the US. Through HCA, the host government attempts to establish its legitimacy by showing its concern for the people as well as its capability to deal with their problems.

In situations in which the US is supporting an insurgency, HCA can serve the same political and psychological purposes in reverse. [7] Actions by the insurgents can help to undermine the trinity by showing a contrast with the current government. Humanitarian actions could be especially effective against a very repressive or incompetent government. As the US discovered in its support of the Nicaraguan "contras," insurgent fighters often bring their families with them or rely on their home villages as bases. In these circumstances, programs that are functionally identical with HCA may be necessary to maintain the insurgents' morale and capabilities.

In both insurgency and counterinsurgency situations, HCA also can present opportunities for intelligence gathering. Granted that the notion of offering medical care in exchange for information is both repugnant and possibly a violation of international humanitarian law, nevertheless civic actions in themselves can be very informative. For example, the number of personnel willing to avail themselves of the services, the kinds of medical problems

encountered, the health status of the population, etc., could all be of considerable intelligence value. Data of this kind could be gathered as a part of the activity itself without any use of coercion or other inhumane or illegal treatment.

Peacekeeping is a special circumstance in which HCA could be of great aid in direct mission support.[8] Such actions could serve both as a means of gathering intelligence and of building a favorable image of the peacekeeping force itself. In addition, HCA also could contribute directly to maintaining peace by lowering the tensions generated within the local population by fear of epidemics and lack of medical services. During the multinational peacekeeping operation in Lebanon in 1983, French forces conducted HCA operations in the areas around their bases with considerable success.

The fourth major end served by military medical systems in LIC is medical intelligence. The primary element of information needed in LIC operations is advance knowledge of the endemic diseases present in the area of operations. This information assists in the preparation of preventive medicine countermeasures to permit troops to operate safely in the environment. An additional element of great value is the capability of the host nation's medical care system. In many circumstances, there may be compelling reasons to use or not to use the host nation's hospitals. Medical intelligence also can be useful in anticipating a potential enemy's intentions. For example, if an enemy were detected in the act of immunizing his personnel against a potential biological warfare

agent, such a program might signal his intention to use the agent against US or friendly forces. In the case of the Persian Gulf war, one of the most convincing indications of the Iraqi intention to invade Kuwait was a national program of blood donation and the clearing of hospitals.

The final end which military medicine aims to achieve in LIC is research. Although the actual field operations may amount to a kind of humanitarian action, the unique purposes of research projects place them in a different category deserving of separate treatment. Most medical research in LIC environments is aimed at developing new methods for prevention and treatment of endemic or "tropical" diseases. Although the funding levels for this kind of research are commonly justified by pointing out the potential impact of these diseases on US personnel, the discoveries made often have their greatest impact on civilian populations. When properly disseminated, new vaccines or drugs developed by military researchers can yield huge benefits in both psychological and economic growth terms.

WAYS

Once the strategic ends toward which military medicine is directed in LIC are defined, the ways in which military medicine can be used become clearer. The most obvious fashion in which the first of the ends is achieved is by including medical units and personnel in US planning. Current force development systems, including Total Army Analysis and the Medical Planning Module of the Joint Operations Planning System, generate requirements for

medical units. However, both the size and support requirements for medical units continue to attract the attention of senior leaders. During Operation Urgent Fury and the early phases of Operation Desert Shield significant pressures were applied to minimize medical force structure on the ground. Current operations planning systems also provide preventive medicine programs for US troops that are based on current medical intelligence, careful analysis of the environment, and thorough consideration of medical concerns.

In efforts to support the second end of military medicine in LIC, program development normally begins with consultation between US personnel and the host government. Rarely, if ever, can standardized programs or approaches be applied in specific cases. US medical planners need to understand the host nation's capabilities, its systems for both health and national security policy development, its health environment, and the nature of the conflict itself.

This initial consultation may reveal that many of the host nation's systems are underdeveloped or entirely absent. In the case of El Salvador, the US consultation team determined that the Salvadorean Army did not have several of the essential elements of an effective military medical care system. For example, a Medical Service Corps to perform administrative functions within the military medical system did not exist. In similar circumstances, one of the first tasks for US personnel would be to assist in the development of organizations to perform the various activities necessary to achieve the ends of military medicine. Systems for

administration, supply, evacuation, and compliance with international humanitarian law may need to be developed and institutionalized within the host government and military. Although treatment systems may exist and function reasonably well in garrison, development and expansion will often be necessary to enable treatment in field environments and for the types of illnesses and injuries that occur in active operations.

As systems are developed and introduced to the host nation's forces, training becomes essential. This training helps ensure the greatest effectiveness of new and old organizations, concepts, and equipment. Typically, US personnel act in a "train the trainers" role in order to foster systems that will be sustainable by the host nation's personnel. Direct use of US personnel as trainers has the disadvantage of increasing the visibility of the military assistance effort as well as enlarging the US presence in the host country.

One form of training that has not been particularly successful in the LIC context is Graduate Medical Education (GME). Attempts to introduce the host nation's physicians into residency training programs in the US have met with considerable resistance. One major problem is the medical credentialing of foreign physicians. In most cases, unless the foreign physician goes through the entire process for obtaining Educational Council for Foreign Medical Graduates (ECFMG) certification, he will not be allowed to treat patients. These restrictions generally prevent training of foreign physicians in US military hospitals and often result in offense to

host nation sensibilities. Foreign physicians who do succeed in entering US GME programs often discover that they are learning techniques and a level of medicine that cannot be practiced in their own countries or, if at all, only in the capital city. All too often, these physicians decide to practice in the capital city, thus exacerbating the typical maldistribution of physicians in less developed countries. They also may choose to remain in the US, adding to the "brain drain" of the best qualified people leaving poorer countries for the "First World."

Foreign Military Sales (FMS) to countries involved in LIC may include medical systems, supplies, and equipment. Typically, however, the purchasers of military equipment in the receiving country may not have much appreciation of the value of military medical care. By far the largest amounts of medical aid the US provides flow through non-Department of Defense programs. Even though this aid may be provided under the aegis of the US Agency for International Development (USAID) or other agencies, it still may have an impact on LIC, especially in a counterinsurgency situation.

The DOD organization responsible for medical intelligence is the Armed Forces Medical Intelligence Center (AFMIC). A full discussion of this agency's activities is beyond the scope of this paper. Suffice it to say that AFMIC's products support precisely the elements of information listed earlier. Most medical intelligence gathering uses open source documents such as medical journals. One particular exception, however, is the use of medical

surveillance data. Questionnaires and biological specimens obtained from returning US personnel provide insights into the likely disease and other health-related experiences of US personnel and help refine predictive models that may be applied to future deployments. Medical surveillance is also useful during deployments to monitor the effectiveness of preventive programs.

Cooperation with host nation research institutions offers another way in which US military medicine can support LIC, albeit indirectly. Exchanges of investigators between US and host nation laboratories open additional channels of communication and help build the host nation's capability to support its own needs. Co-investigation in research laboratories and co-publication are usually not limited by the restrictions discussed earlier under GME.

In the development of this paper, humanitarian/civic action as a way of prosecuting LIC is discussed last for two reasons: Firstly, it is the most familiar to both medical and non-medical personnel. Secondly, despite the limitations of this mechanism, HCA will likely be the most common and visible program in future LIC campaigns. Given that likelihood, a set of guidelines for obviating some of the problems with this type of activity and improving its usefulness as an instrument of policy are needed. These guidelines apply to all military medicine, but have their greatest impact in the conduct of HCA.

Not just in the present public affairs environment, but fundamentally in any case, military medical systems must operate in

strict compliance with international humanitarian law.[9] In fact, the Red Cross movement and one of the two major branches of the doctrine of jus in bello, the body of law regulating conduct in war, had their origin in the failure of military medical care on the battlefield of Solferino, 1859.[10] A full consideration of the Geneva Conventions and Additional Protocols would be the subject of another paper. Suffice it to say that Geneva law does apply fully in LIC, especially after the adoption of the Additional Protocols of 1977. The essence of Geneva law is the protection of the victims of war and the provision of medical care in a non-discriminatory and non-coercive fashion.

In LIC campaigns, several specific situations pose special risks for inadvertent violations of law. The first of these is the treatment of prisoners of war. The Additional Protocols have the effect of making virtually any person taking part in a form of LIC technically a "combatant."[11] Once captured, a combatant is entitled to protection and other privileges that may exceed those available to a civilian national of the host country. In such a case, the argument is often whether the captured individual is a legitimate prisoner of war or a common criminal.

A second highly charged area for possible violations concerns the medical facilities of opposing forces. These may be operating in a clandestine fashion, but, once discovered, they are entitled to the protections of Geneva law. Moreover, as the Salvadorean forces learned in their campaign against the FMLN, even inadvertent attacks against clandestine medical facilities offer major

propaganda opportunities to the opposition and threaten the loss of US Congressional support.

Although not strictly a feature of the Geneva Conventions and Protocols, performing research on human subjects also can present legal and propaganda risks in a LIC environment. Using host nation personnel as subjects opens the US to allegations of coercion and of using "human guinea pigs." In the instances in which these studies have been successful, investigators have been careful to ensure that host national scientists are thoroughly involved in the design and conduct of the studies. Moreover, it has proved valuable to obtain the approval of regulatory bodies in both countries which oversee this specific kind of research.

US medical research activities have also been the object of disinformation campaigns. One of the most scurrilous and successful of these alleged that the US developed the Human Immunodeficiency Virus, the cause of Acquired Immunodeficiency Syndrome (AIDS). The supposed objective of the US action was to force population control on the growing nations of the third world. Although the Soviet Union reportedly agreed some years ago to cease its efforts to spread this calumny, the allegation appears periodically in the news media of several nations.

The second guiding principle for military medicine in LIC and especially in HCA is to place the emphasis on developing capability, not providing service. It is clearly beyond the means of any US military force to supply all the medical needs of another nation. Our efforts should assist the host nation in building the

systems needed to provide these services to its own people.

As previously stated, the real objects of civic and humanitarian programs are political and psychological. Thus, these kinds of programs must always be performed under host nation or force sponsorship. The goal is to reinforce the trinity within the host nation, not to forge a new one with the US. If the US presence is too visible, the psychological impact may undermine the credibility and, thus, the legitimacy of the host government and army by showing their lack of capability.[12]

US personnel need to keep an additional political consideration in mind in planning the development of HCA programs. That consideration is the reality of tension between the host nation's military and civilian power structures. US military personnel must be conscious that their uniformed status will color the reaction of some officials of civilian health ministries and voluntary organizations.[13] Regrettably, the tradition of the supremacy of civil government is not well established in many less developed nations, making military coups all too frequent. Civilian officials may be concerned with maintaining the status of their agencies and, thus, the position of the civil government against military authorities in their own countries. It is also distinctly possible that officials of civil government or voluntary agencies may favor the insurgency or, in fact, be members of its leadership.

As the operational guideline, HCA programs need to be targeted to fulfilling some appropriate need. Consideration must be given

to the differences between urban and rural health needs and capabilities. Especially in countries that are experiencing rapid development of some phases of their economies, contrasts between these segments of society may be extreme and may be a source of support for insurgents.[14] Clearly, an HCA program that appeared to exacerbate the contrasts would be counterproductive.

HCA programs need also to consider the demographic and cultural characteristics of the host nation. Although commonalities do exist among most developing nations--rapid population growth, low median population age, high infant mortality--there is danger in overgeneralizing. The psychological and political acceptability of programs will vary tremendously depending on religious and other factors in each specific case. Contraceptive services are perhaps the most obvious example of this phenomenon.

In general, the most successful HCA programs place their emphasis on primary care and prevention. One of the more notable successes has been the introduction of oral rehydration therapy for infants suffering from diarrhea. For a variety of reasons including the scarcity of potable water, declines in breast feeding, and urbanization, diarrhea with its attendant dehydration is the greatest cause of infant mortality in the world. The typical developed world treatment--intravenous rehydration--requires a range of products and services that are usually absent or unobtainable for third world mothers. It should be borne in mind that, in many nations, the price of a single liter of

intravenous fluid may exceed the nation's annual per capita expenditure on health. Happily, oral rehydration using techniques and materials that are readily learned and acquired is fully as effective in saving babies.

The other great success story in HCA is immunization. Although this effort is carried out under the aegis of the World Health Organization (WHO) Expanded Program for Immunization--the successor to WHO's incredibly successful smallpox eradication effort--at the ground level it lends itself perfectly to HCA. Immunization is one of the few examples of a program that can have a significant impact on health with only a brief period of involvement in the area. As such, it may be suitable for use in areas where physical security cannot be assured for long periods of time. Conversely, however, since immunization prevents something that otherwise might or might not occur, its effects are not as readily identified by the recipients. To use the smallpox example, the majority of the populations where this disease was a recent problem have no memory of it since they were born since eradication. Consequently, the psychological value of smallpox eradication now is almost nil even though it is responsible for much of the increase in population in the third world.

Another form of HCA that can be extremely effective, especially in rural areas, is animal health. Both in subsistence and rural cash economies, domestic animals represent considerable productive capacity and investment. Programs which improve the survival and output of cattle, sheep, swine, and other animals used

for power and food have psychological value and contribute to economic development.

A serious pitfall of HCA, especially when done by US personnel with their fondness for high technology medicine, is the creation of unachievable expectations in the minds of the recipients.[15] Developing systems for primary health care and prevention requires a sustained level of effort over the long term as well as the full range of backup services and institutions such as referral hospitals, specialized medical personnel, training establishments, etc. Achieving this standard is often beyond the present means of the host government and may require decades of sustained investment and development. The products of this investment and development are often the precise targets of insurgent movements.[16] Consequently, HCA programs that create unrealistic expectations can often combine with insurgent attacks on the infrastructure necessary to achieve them to lower the host government's credibility and legitimacy.

In the development of HCA or other medical assistance programs, planners must recognize that the principal limitation is inadequate infrastructure. The obvious ones of poor sanitation and lack of access to potable water are evident throughout much of the Third World. Housing which provides inadequate protection from insect vectors is another clear risk to health. HCA programs that fail to consider these prominently risk falling into a pattern of treating the symptoms rather than the cause of ill health. Even within the health care delivery system, frequently the limiting

factors are infrastructural: lack of reliable electrical power and poor transportation. Many medical products are extremely perishable. Without refrigeration and rapid transport, these products cannot be delivered to populations in need.

It should be clear from the preceding discussion that HCA programs such as MEDCAP suffer from the use of means that are frequently inappropriate for the accomplishment of missions. Since they are normally structured to provide combat casualty care, US medical forces emphasize treatment of traumatic injuries. Most of the time these capabilities are not the most useful or needed. The one exception, of course, is disaster assistance such as the efforts to relieve the Nicaraguan and Guatemalan earthquakes of the 1970's. Even in these examples, however, by the time the US hospitals arrived and became operational, many of the patients who could have benefitted from trauma care had either died or been treated by the surviving host nation capabilities.

In comparison to our often inappropriate medical care facilities, US logistic capabilities may have more real impact. Since many of the greatest barriers to successful host nation health programs are inadequate infrastructure, the US may be able to remedy these deficiencies. Providing vehicles, improving roads, operating generators, etc. may be the most valuable contributions the US can make. Moreover, these efforts are less visible and thus less likely to have inadvertent psychological effects.

As discussed in the introduction, US HCA programs are often the result of pressures to "do something" with existing medical

units and personnel. As a consequence, these efforts are infrequently evaluated against any standards of effectiveness. It is generally assumed that, since providing medical services to people is a positive good, the more services the better. This assumption fails to consider the notorious elasticity of medical care demand nor does it take into account that episodic treatment of endemic diseases is usually of little value. Evaluation by counting the number of services rendered, patients seen, etc. is easy, but generally useless since no effort is made to measure the effects on the population.[17] Unfortunately, significant changes in morbidity or mortality are often very difficult to detect, especially in the short term. Moreover, typical HCA programs cannot be expected to alter greatly the health status of a population beset by so many problems.

Given these circumstances, evaluation of HCA may seem frustrating. However, when it is recognized that the real purposes of HCA programs are psychological and political, their usefulness can be evaluated more readily. Viewed in the context of the overall mission, HCA can be evaluated according to the progress of US objectives. In the case of a counterinsurgency, success might mean evidence of declining support for the insurgents and increasing legitimacy of the host government. Conversely, in the case of a US-supported insurgency, increased effectiveness of the insurgent forces and loss of political support for the government might be the key indicators of progress.[18]

MEANS

In discussing the means by which US ends are pursued, this paper will first deal with existing capabilities. The author will then propose a range of additional units, personnel, and capacities that would enhance the effectiveness of military medicine in LIC. The first existing capability that must be mentioned is the presence on the staff of each of the Unified Command CINC's of a full-time Command Surgeon. This achievement was finalized with the separation of the US European Command Surgeon position from that of Commanding General, 7th Medical Command, in the early 1980's. With two exceptions, these Command Surgeons are general/flag officers. As such, they can provide high level input into operations plans and other activities of the Unified Commands.

The Unified Command Surgeons can call upon their own resources as well as those of the three Service medical departments for consultations with host governments. Most of the specialties and skills needed for the creation or development of military medical systems and subelements will be found within one or more of the Services. Once consultation has determined the kinds of assistance or development needed, the Command Surgeon is ideally placed to facilitate US support. In the event that consultation reveals the need for additional training and training assistance, teams can be formed to provide the kinds of training required. Recent examples of medical training teams include those in El Salvador and Honduras.

Cooperative medical research efforts are normally coordinated between the host government and the US Army Medical Research and Development Command, the DOD Executive Agent for infectious disease research. Overseas research stations operated by both the Army and Navy provide opportunities and resources for original investigation and medical consultation. A current example of cooperation at this level is the support being given to the government of Peru by the Army-Navy infectious disease research laboratory in Lima. This effort is aimed at controlling an epidemic of cholera that has affected much of the coastal areas of Peru. This epidemic and the Peruvian government's ability to control it may have profound implications for the campaign against the Sendero Luminoso and Tupac Amaru, two particularly virulent Marxist insurgencies, the former of which has gained considerable support among disaffected Quechua-speaking elements in Peru.[19]

On a more prosaic level, existing US transportation capability also can contribute to medical activities in LIC. Our ability to move equipment and medicines rapidly and evacuate patients can be extremely valuable in assisting host governments to respond to crises. In a crisis, US transportation support could be useful in at least temporarily overcoming deficits in infrastructure. Transportation support can be direct in which US forces actually perform the missions or indirect by supplying vehicles and aircraft to host nation units.

US deployable medical facilities also can be of value in crises since they can be moved in and established very rapidly. In

the example of the Nicaraguan earthquake of 1972, a US field hospital became the main medical treatment facility for much of Managua since the fixed facility had been destroyed. It is also possible to set up deployable medical equipment in so-called non-industrial facilities (NIF) which then can be used as hospitals. Current US doctrine also provides medical input in psychological operations and civil affairs. Existing psyops and civil affairs units, most of which are in the Reserve Components, have slots for medical personnel.

A persistent problem with the deployment of US military units in support of LIC, especially in the HCA context, is that the overwhelming majority of the forces available are in the reserve components. Moreover, current law requires that, absent mobilization, their missions must take place during annual training and may be the only "hands on" training the troops receive. The brevity of the deployment as well as the organizational needs of the reserve component unit often limit the productivity of the effort. Explaining this to the US Ambassador and the host nation's officials is often difficult.[20]

Notwithstanding the considerable capacities that already exist, full implementation of a strategy for military medicine in LIC will require creating capabilities that do not yet exist in the Services' medical departments. The most critical element must be a cadre of medical personnel who will spend their careers in LIC; in other words, a group of Medical Foreign Area Officers (MFAO). MFAO would receive training in languages, exotic diseases, joint

operations, LIC, etc. Since their primary duties would not be treatment of patients, MFAO need not be clinicians. In fact, they do not necessarily need to be physicians at all. The skills of greatest value in MFAO would be those of preventive medicine specialists, sanitarians, public health nurses, administrators, medical logisticians, public health veterinarians, etc. A career path for MFAO would include service in Unified Commands, Military Assistance and Advisory Groups, Service schools, and headquarters. It should be noted that the concept of MFAO is not original with the author. The idea was enunciated more than a decade ago by BG Richard Proctor, now Commanding General of William Beaumont Army Medical Center.[21]

The second critical element to the full implementation of military medical strategy in LIC is the development of specialized medical units.[22] These would not be based on deployable treatment facilities since, as has been shown, much of the proposed strategy does not involve direct treatment of patients. The missions for these units would include consultation, evaluation, logistics planning, program design, training, etc. A key element is that these units must be designed and missioned exclusively for LIC. Without this element, units and personnel will continue to perform LIC missions on an ad hoc basis. In this circumstance, the full implementation of a strategy of military medicine in LIC cannot occur, new lessons will not be captured, and the Services will be condemned to repeat the limited successes of the past. Lastly, these units need to be in the active components of the

Services so that their missions can be accomplished without the need for reserve call-up or mobilization. In contrast, it should be noted that the overwhelming majority of PSYOPS, civil affairs, and medical units in the Army are in the reserve components.[23]

SUMMARY

Despite the episodic and often unfocused nature of military medical activity in LIC over the past decades, much good has been done. It is not meant as criticism of the participants to say that many of those programs resulted from impulse and had limited impact. At least from a humanitarian point of view, they benefitted people. However, the benefits went to a relatively few people and were not directed against the greatest needs of the population. Most significantly, these efforts did not result from a coherent strategy. The concern of this author is that these benefits to individuals or groups were provided in ways that presented real risk to the host nations' governments. These risks included building expectations that the host nation could not fulfill as well as transmitting a subtle but unmistakable message that the host government was incapable of meeting its citizens' needs. In political terms, which are the real issues in LIC, the results of US programs may have been unintentionally more helpful to the insurgents than the government.

In the author's view, the central problem with past medical LIC efforts is that the US used hospitals and personnel deployed for combat to perform another distinct mission. Of necessity, many of these LIC efforts were episodic ad hoc programs that had little

long term impact. It is also no criticism to note that personnel assigned to an area for twelve months (or six months in Honduras) to do a combat mission cannot devote themselves fully to LIC. Future military medical activities in LIC must originate from the particular strategic ends, ways, and means that govern this field of military operations. Just as with any US military activity, medical operations, units, and policies must be planned and designed for the advancement of US interests. Only with a clear understanding of the principles which underlie the application of military medicine to Low Intensity Conflict can the medical departments fulfill their full role in achieving our national strategy.

ENDNOTES

1. John A. Parrish, MD, 12, 20 & 5, A Doctor's Year in Vietnam, pp. 64-70.

2. In his 1988 USAWC Military Studies Project, COL Elray Jenkins, MC, exhaustively reviewed the history of MEDCAP and the successor Medical Readiness Training Exercise (MEDRETE). He concluded that no clear doctrine or policy for military medical participation in HCA existed. COL Jenkins' successor as Commander of the US Army hospital in Honduras, COL Hood, echoes those views in his 1991 article in Military Medicine.

3. In her monograph written for the Strategic Studies Institute, Dr. Regina Gaillard argues that civic action should be delinked from LIC counterinsurgency doctrine and pursued independently by a new US Development Corps.

4. Field Manual 100-20/Air Force Pamphlet 3-20, Military Operations in Low Intensity Conflict, 1 December 1989, p. 1-10.

5. At present, there is no single textbook of military medicine published in English. The Surgeon General, US Army, has directed the publication of a comprehensive textbook (presently comprising eighteen volumes), parts of which have been published in the past several years. This author's article on military medicine will be published in Brassey's International Military and Defence Encyclopedia in 1992.

6. Philip S. Yang, MAJ, US Army, "Psychological Strategies for Low-Intensity Conflict," CLIC Papers, October 1988, p. 12.

7. As detailed in Lt Col William F. Furr's article entitled "Low-Intensity Conflict Policy and Strategy Statements," CLIC Papers, January 1989, the US has gradually recognized that our interests may be served in some cases by supporting insurgencies.

8. Yang, p. 32.

9. Bahnsen and Burgess' "Twelve Rules" begin with the reminder that the US is held to a higher ethical standard than any other nation. Even the appearance of a violation of international law has been fatal to US programs.

10. The other main branch of the doctrine of jus in bello is usually called "Hague law." Hague law is primarily concerned with prohibited weapons in warfare such as explosive bullets or with prescribing activities of combatants such as entry of warships into neutral ports, etc.

11. The Preamble to Protocol I reaffirms that protections must be applied "without any adverse distinction based on the nature or origin of the armed conflict or on the causes espoused by or attributed to the parties to the conflict." Article I specifically mentions "armed conflicts in which peoples are fighting against colonial domination and alien occupation and against racist regimes in the exercise of their right of self-determination..." Any self-respecting LIC leader who cannot place his cause under at least one of those rubrics just is not trying.

12. Peter Bahnsen and CAPT William H. Burgess, III, USA, "US Aid to Democratic States Facing Totalitarian Revolutionary Warfare: Twelve Rules," CLIC Papers, December 1987, p. 8.

13. Donald J. Bruss, MAJ, USA, "The Emerging Role of US Military Health Care in Low-Intensity Conflict," in Low-Intensity Conflict and Modern Technology, ed. by David J. Dean, Lt Col, USAF, p. 227.

14. Bruss, pp. 224-5.

15. William H. Thornton, MAJ(P), USA, "Army Medical Department Roles and Functions in Low Intensity Conflict," in CLIC Papers, August 1987, pp. 4-5.

16. Bruss, p. 228.

17. Bruss (p. 230) goes as far as to suggest that evaluation by counting numbers of patients seen, teeth extracted, etc. is equivalent to the "body count" used in measuring battlefield success and equally as useless.

18. Colonel Howard L. Dixon, USAF, in his monograph "A Framework for Competitive Strategies Development in Low Intensity Conflict," CLIC Papers, April 1988, proposes a set of measures of merit for evaluating strategies on political grounds which are readily applicable to HCA.

19. At this writing (March 1991) the situation in Peru has taken yet another bizarre twist. A Health Department spokeswoman accused the Peruvian President, Alberto Fujimori, of making the cholera epidemic worse by encouraging Peruvians to eat sushi.

20. Kenneth G. Brothers, Lt Col, USAF, "Reserve Component Support to United States National Low Intensity Conflict Strategy: Future Issues," CLIC Papers, April 1989, pp 27-8.

21. Thornton (p.9) also discusses this concept under the rubric of Regional Medical Experts and advocates their assignment to Unified Command headquarters.

22. Thornton, p. 8.

23. Howard L. Dixon, Col, USAF, "The Role of Reserve Forces in Low Intensity Conflict," CLIC Papers, August 1987, p. 6.

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